

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Sep/17/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

97799 Chronic Pain Management Program 5xwk x2wks

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

M.D., Board Certified Pain Medicine

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. The reviewer finds medical necessity does not exist for 97799 Chronic Pain Management Program 5xwk x2wks.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 07/24/12, 08/14/12

Independent review organization summary dated 08/27/12

Employer's first report of injury or illness dated 08/06/07

Associate statement dated 08/01/07

Bona fide job offer dated 09/04/07, 09/12/07, 01/19/08

Office note dated 08/01/07, 08/09/07, 09/10/07

Physical therapy progress note dated 08/20/07, 08/22/07, 08/27/07, 08/29/07, 08/30/07, 09/05/07, 09/06/07, 10/03/07, 10/04/07, 10/11/07, 10/17/07

Radiographic report dated 08/05/07

Progress note dated 06/25/09, 07/23/09, 08/20/09, 09/17/09, 09/24/09, 10/15/09, 11/09/09, 11/12/09, 12/03/09, 12/11/09, 01/08/10, 02/05/10, 03/09/10, 04/07/10, 05/05/10, 06/02/10, 06/30/10, 07/28/10, 08/23/10, 09/21/10, 10/19/10, 11/16/10, 01/12/11, 02/09/11, 03/05/11, 04/05/11, 05/03/11, 06/02/11, 06/30/11, 07/28/11, 08/25/11, 09/20/11, 10/18/11, 10/26/11, 11/15/11, 12/14/11, 01/12/12, 01/19/12, 02/09/12, 02/16/12, 03/15/12

Request for 10 day trial chronic pain program dated 06/25/12

Initial interview dated 03/12/12

Lab reports various dates

Handwritten note dated 11/18/11

IRO dated 12/22/10

Soap notes dated 08/07/07-01/08/09

Pain management notes dated 08/27/08-05/28/09

Procedure note dated 02/19/09
Initial narrative report dated 01/14/09
Functional capacity evaluation dated 01/21/09, 12/15/09, 06/25/12
Request for reconsideration dated 08/07/12
Designated doctor evaluation dated 03/19/08, 03/12/09
Peer review dated 10/24/07
Lumbar spine MRI dated 10/01/07, 08/26/09

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. On this date the patient was lifting a box off the floor. The patient was seen and diagnosed with a lumbar sprain. Peer review dated 10/24/07 indicates that the patient underwent a course of physical therapy. The reviewing physician opines that the patient sustained a self-limiting soft tissue injury to the lumbar spine. One would anticipate that the subjective complaints of low back pain accompanying this type of soft tissue injury would resolve within 60-90 days with appropriate conservative treatment. Designated doctor evaluation dated 03/19/08 indicates that diagnoses are displaced disc lumbar spine; vertebral lumbar strain and low back pain. The patient was determined to have reached maximum medical improvement with 5% whole person impairment. The patient underwent lumbar epidural steroid injection on 02/19/09. Re-evaluation dated 03/12/09 indicates that the patient really has not made any great improvement. Initial interview dated 03/12/12 indicates that the patient has utilized a TENS unit, but nothing seems completely successful in lowering her levels of pain. Medications at that time are listed as Lortab, Soma, Lyrica and opium. BDI is 40 and BAI is 39. FABQ-W is 42 and FABQ-PA is 24. Diagnosis is pain disorder with both psychological factors and a general medical condition. Request for 10-day trial chronic pain program dated 06/25/12 indicates that current medications are Lortab, Soma and Lyrica. Beck scales are unchanged. Functional capacity evaluation dated 06/25/12 indicates that current PDL is sedentary and required PDL is medium.

Initial request for chronic pain management program 5 x 2 weeks was non-certified on 07/24/12 noting that the report submitted for this request has the same information as the report from 03/12 for the request for psychotherapy. It is difficult to believe that the patient obtained exactly the same scores on the testing from 03/12 on 08/25/12. Regardless, she has not had active treatment in years, is at MMI and has not attempted to return to work in any capacity. The denial was upheld on appeal dated 08/14/12 noting that she is no longer eligible to return to her job and the return to work plan is a DARS referral. The patient has Beck scales over 40 and negligible physical strength based upon physical testing. Based upon this review, it appears that the patient is offering significant exaggeration of her physical abilities and psychological sequelae.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The patient sustained injuries over x years ago. The Official Disability Guidelines do not support chronic pain management programs for patients who have been continuously disabled for greater than 24 months as there is conflicting evidence that these programs provide return to work beyond this period. There is no indication that the patient has undergone any recent active treatment. The patient has been determined to have reached MMI by a designated doctor with 5% whole person impairment. Peer review dated 10/24/07 indicates that the reviewing physician opines that the patient sustained a self-limiting soft tissue injury to the lumbar spine. Subjective complaints of low back pain accompanying this type of soft tissue injury would typically resolve within 60-90 days with appropriate conservative treatment. The reviewer finds medical necessity does not exist for 97799 Chronic Pain Management Program 5xwk x2wks.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

☐ AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☐ DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ INTERQUAL CRITERIA

☒ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)